

FIRST GI ENDOSCOPY AND SURGERY CENTER, LLC
BHARAT DASANI MD (Director)

PREOPERATIVE EVALUATION

Allergies:		<input type="checkbox"/> NKA <input type="checkbox"/> Yes: If Yes, Reaction: _____	
Latex Allergy:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
YES	NO	CONDITION	COMMENTS
		Have you traveled outside the country in the last month?	
		Recent hospitalization or change in health status?	
		Have you had a fever in the last 24 hours? Recent infections?	
		Have you had diarrhea/vomiting in the last 24 hours?	
		Do you currently have a cough, sore throat, night sweats?	
		CAD/Angioplasty/Angina/Mitral Valve Prolapse/ CHF?	
		Heart Attack/Chest pains? when? Follow up?	
		High Blood Pressure/High cholesterol?	
		Pacemaker/Defibrillator or other implantable device? Cardiologist Name ?	
		COPD/Emphysema/Bronchitis/TB/SOB?	
		Asthma? Last attack? Rescue inhaler?	
		Sleep Apnea? CPAP? Home Oxygen?	
		Diabetes IDDM/ NIDDM Insulin pump?	
		Liver Disease/Jaundice/ Hepatitis? A? B? C?	
		Kidney Disease? Dialysis? How often? Last treatment?	
		Blood Thinners/ Aspirin or similar Medications?	
		Seizures/Epilepsy/Arthritis/DJD?	
		CVA/TIA? Results?	
		Physical Limitations? Wheelchair/cane/crutches/etc.	
		Thyroid Disease?	
		Cancer?	
		Bleeding Disorders?Anemia?HIV? or Any other medical condition?	
		Do you smoke? How much? How long?	
		Do you drink alcohol? What type? How Much?	
		Do you use illegal drugs/ Type? Last use?	
		Any other surgeries?	
		Any complications from anesthesia?	
		Any family member with anesthesia complications?	
		Females: LMP?	
		Your Primary Physician:	
Height		Weight	
Comments:			
RN Name and Signature:			